CONNECTICUT WOMEN'S HEALTH CAMPAIGN

c/o Permanent Commission on the Status of Women
18-20 Trinity Street Hartford, CT 06106
Phone: (860) 240-8300 E-mail: pcsw@cga.ct.gov
Fax: (860) 240-8314 Website: www.cga.ct.gov/pcsw

The Connecticut Women's Health Campaign

Advocacy for Patients with Chronic Illness, Inc.
African American Affairs Commission
American Cancer Society
American Heart Association
CT Association for Human Services
CT Association of Nonprofits
CT Association of Substance Abuse Agencies
CT Breast Cancer Coalition, Inc.
CT Citizen Action Group
CT Coalition Against Domestic Violence
CT Coalition for Choice
CT Community Care, Inc.
CT Legal Rights Project
CT NOW
CT Primary Care Association
CT Sexual Assault Crisis Services
CT Women and Disability Network, Inc.
CT Women's Consortium, Inc.
Latino and Puerto Rican Affairs Commission
NARAL Pro-Choice Connecticut
National Council of Jewish Women
National Ovarian Cancer Coalition CT
New Haven Legal Assistance Association
Older Women's League of NWCT
Permanent Commission on the Status of Women
Planned Parenthood of CT, Inc.
Quinnipiac University, Department of Nursing
R.O.C.C.S.-Research for Ovarian Cancer & Continued Survival
Ruthe Boyea Women's Center, Central CT State University
UCONN School of Allied Health-Asian American Studies Institute
UCONN Women's Center
University School of Medicine, Office for Women in Medicine

Briefing Papers on Women's Health FEBRUARY 2006

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2006 Legislative Agenda

Access to Healthcare

Medicaid Restoration

- Eliminate co-payments and premiums on adults in the HUSKY A/Medicaid program.
- Simplify HUSKY eligibility and enrollment.
- Appropriate funds for Medicaid coverage of smoking prevention and cessation programs. (see also "prevention")

Gender Appropriate Behavioral Health Services

Support proposals for pilot programs to demonstrate and evaluate "best practices" in providing gender-appropriate treatment services for women and girls with behavioral health needs.

State Administered General Assistance (SAGA) Restoration

- Lift the cap on appropriations for this program and seek restoration of coverage for non-emergency medical transportation and other "optional" services such as vision, podiatry, and home health care.
- Support proposals to institute certain due process rights and protections for enrollees.

Access to Prescription Medications

Support proposals to strengthen patient protections in programs with preferred drug lists or prior authorization requirements.

Reproductive Health Care

Protect access to the full range of reproductive health care and choice, including emergency contraception, which should be available to all women, and particularly to survivors of sexual assault who may seek care in emergency departments.

Cancer Detection and Treatment

Support proposals to increase funding and expand access to early breast, cervical and ovarian detection services and treatment.

Racial and Ethnic Disparities in Health Care

Monitor the impact of proposed legislation and raise awareness about racial and ethnic disparities in health care for women.

Prevention & Gender Competent Services

Nutrition and Physical Activity
Support proposals that address the need for nutritional education and services in an effort to address preventable health conditions, particularly eating disorders and obesity.

Smoking Prevention and Cessation Programs
Support proposals to appropriate funds for Medicaid coverage of smoking prevention and cessation programs.

Domestic Violence Programs
Support proposals to provide funding to increase services and shelter staff for victims of domestic violence, particularly women with disabilities.

Sexual Assault Services
Protect funding for sexual assault centers in order to ensure that victims of sexual assault receive comprehensive rape crisis services, support the rights of sexual assault victims and support legislation to prevent and end sexual violence against women.

Community Health Services

Home & Community Based Services
Support proposals to provide home and community based services for chronically ill and disabled individuals from ages 18 to 65.

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Gender-Responsive, Trauma Informed and Culturally Sensitive Services Needed Across Service Delivery Systems for Women with Behavioral Health Needs

The Connecticut Women's Health Campaign, in collaboration with the Roundtable on Women's Behavioral Health[1], recognizes and supports the need for comprehensive, integrated service models for women with co-occurring substance abuse, mental illness, and trauma[2].

The following definition of gender responsive is the foundation for creating and maintaining comprehensive, integrated service models for women:

> Being gender-responsive means creating an environment through site selection, staff selection, program development, content, and material that reflects an understanding of the realities of the lives of women and girls and that addresses and responds to their strengths and challenges.[3]

The Problem

Over the past twenty years, much knowledge concerning the unique needs of women has been gained in the fields of mental health, substance abuse and trauma treatment. The most recent findings come from the Women, Co-occurring Disorders and Violence Study (WCDVS). Women in the study who received counseling that addressed all three aspects of their lives together (mental and substance abuse disorders and histories of violence [trauma]) improved more than women in usual care, which tends to be fragmented and uncoordinated. Women's symptoms also improved when they participated in the planning, implementation and delivery of their own integrated services.[4] This knowledge has yet to be applied in the majority of programs serving women.[5]

Research on female development has revealed key differences in the psychosocial development of females and males.[6] Such research is furthering our understanding of the role that socialization and relationships play in women's lives and behaviors. Research has also highlighted important strengths and challenges associated with females' cultural and ethnic backgrounds.[7] For example, new theories are highlighting culturally influenced differences in female socialization processes, female responses to abuse, and female risk/protective factors for system involvement.[7] In order to operationalize what we are learning about delivering gender responsive, trauma informed and culturally relevant services, policy makers, administrators, direct services providers and funders need to acknowledge

women's differences and build an infrastructure that embraces women's gender and cultural/ethnic strengths.

What Can Be Done

Using the following six guiding principles and strategies for implementing them,[8] continue to –

- increase awareness among consumers, providers, administrators, funders and legislators of the need for gender responsive, trauma informed and culturally sensitive services within all delivery systems that serve girls and women;
- work collaboratively with state agencies including, but not limited to, the Departments of Mental Health and Addiction Services (DMHAS); Children and Families (DCF); Corrections (DOC) and the Court Supported Services Division (CSSD) of the Judiciary Branch in their efforts to design, implement and maintain gender responsive, trauma informed and culturally sensitive services to the girls and women who seek care and services from one or more of these state agency's systems; and
- recognize and support successful gender responsive programming and services.

Guiding Principles:

Evidence drawn from a variety of disciplines and effective practice suggests that addressing the realities of women and girls' lives through gender-responsive policy and programs is fundamental to improved outcomes at all levels of service. The six guiding principles that follow are designed to address system concerns about the services and treatment of females in the social service system.

- Gender: Acknowledge that gender makes a difference.
- Environment: Create an environment based on safety, respect, and dignity.
- Relationships: Develop policies, practices and programs that are relational and promote healthy connections to family, children, peers, and the community.
- Services: Address the issues of substance abuse, mental health, and trauma through comprehensive, integrated, and culturally relevant services.
- Socioeconomic Status: Provide women and girls with opportunities to improve their socioeconomic status.
- Community: Establish a system of comprehensive and collaborative community services.[8]

Together with the general strategies for their implementation, the guiding principles provide a blueprint for a gender-responsive approach to the development of effective policy.

General Strategies:

To implement the guiding principles, the following overarching strategies can be applied to each of the principles:

- Adopt — Each principle is adopted as policy on a system-wide and programmatic level.
- Support — Principle adoption and implementation receives the full support of the administration.
- Resources — An evaluation of financial and human resources is done to ensure that adequate implementation and allocation adjustments are made to accommodate any new policies and practices.
- Training — Ongoing training is provided as an essential element of the implementation of gender-responsive practices.
- Oversight — Oversight of the new policies and practices is included in management plan development.
- Congruence — Procedural review is routinely conducted to ensure that the procedures are adapted, deleted, or written for new policies**.**
- Environment — Ongoing assessment and review of the culture/environment take place in order to monitor the attitudes, skills, knowledge, and behavior of administrative, management, and line staff.
- Evaluation — An evaluation process is developed to consistently assess program management and services.[8]

For additional information, please contact:

The Connecticut Women's Consortium
205 Whitney Avenue
New Haven, CT 06511
(203) 498-4184
E-Mail: info@womensconsortium.org

[1] The CT Roundtable on Women's Behavioral Health, a joint initiative of the Permanent Commission on the Status of Women (PCSW) and the CT Women's Consortium (CWC), is a vehicle for sharing practical information that can inform and enhance access to services; advocating for available, affordable and appropriate gender specific policy and programs; and collaborating and coordinating the full range of behavioral health and related services needed by women. The Roundtable has been working on increasing, within state agencies' service delivery systems, the provision of gender responsive, trauma informed and culturally sensitive programs and policies.

[2] The Women, Co-occurring Disorders and Violence Study (WCDVS), a five-year study conducted by SAMHSA of over 2,000 women with co-occurring mental and substance abuse disorders and trauma history.

[3] Bloom & Covington, October 5, 2004 *"Creating Gender-Responsive Services for Women and Girls in Connecticut".* Paper prepared for the CT Women's Consortium, New Haven, CT.

[4] The Women, Co-occurring Disorders and Violence Study (WCDVS)

[5] Bloom, eds., 2003. Gendered Justice: Addressing Female Offenders. North Carolina: Caroling Academic Press.

[6] Gilligan, 1977. "In a Different Voice: Women's Conception of Self and Morality." Harvard Educational Review, 47. and Gilligan, 1982. In a Different Voice: Psychological Theory and Women's Development. Cambridge: Harvard University Press.

[7] Benedict, 2003. Capacity Building: Developing a Gender Responsive Justice System for Young Women in the State of Rhode Island/ A Focus Group Study.

[8] Bloom & Covington.

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Racial & Ethnic Disparities in Healthcare

The Connecticut Women's Health Campaign supports increased education and awareness, early intervention and treatment, and equal access to health care to address racial and ethnic disparities in healthcare.

The Problem

In Connecticut, the leading causes of death for women are major cardiovascular disease, cancer, diabetes, chronic lower respiratory, and HIV/AIDS.[1] There is a clear racial and ethnic disparity as African-American and Hispanic women are at a greater risk for these diseases than White women. The extent of the problem with Asian populations is unknown due to lack of sufficient data.

Major Cardiovascular Disease

African-Americans are at greater risk for heart disease, stroke and other cardiovascular diseases than Caucasians. The prevalence of these diseases in Black females is 39.6%, compared to 23.8% in White females.[2] High blood pressure is a leading cause of stroke. The rate of high blood pressure for Black/African-American females age 20 and older is 44.7%.[3] The risk of heart disease and stroke increases with physical inactivity. Physical inactivity is more prevalent in women, African-Americans and Hispanics.

Cancer

Lung Cancer

In 1987, lung cancer surpassed breast cancer as the leading cause of cancer-related deaths for women.[4] African American women have the highest rates of lung cancer incidence, followed by Caucasian, Asian Pacific, Hispanic and American Indian/Native Alaskan women.[5] In the United States, lung cancer is the leading cause of cancer deaths in the Hispanic community.[6] Between 1999 and 2002 in Connecticut, Hispanic women had a 32% incidence rate of lung cancer.[7] Smoking is the primary cause of lung cancer, followed by exposure to secondhand smoke.

Breast Cancer

In Connecticut, White women have a breast cancer incidence rate of 135.5. This rate is higher than Blacks (121.7), Asian and Pacific Islanders (109.3) and Hispanics (107.2). However, Black women have a

higher estimated mortality rate than White women, 33.8 and 25.4 respectively.[8] The disparity between incidence and mortality rates is attributed to Black women being diagnosed with breast cancer at a later stage, when five-year survival is less likely.[9] This data strongly suggests that early detection of breast cancer in Black women would reduce the disproportionately high mortality rates experienced by this group. In addition to getting regular mammograms the American Cancer Society recommends increased physical activity, minimal alcohol consumption and the avoidance of obesity as ways to reduce the risk of breast cancer.[10]

Ovarian Cancer

Ovarian cancer is the fifth most common cancer found in American women and occurs in 1 out of 57 women.[11] In 2004, approximately 25,500 women were diagnosed with ovarian cancer, and about 50 percent of diagnosed women died within five years of cancer detection.[12] There are racial disparities connected with this disease. In 2000, the death rate among African American women was 5.9 per 100,000, compared to 3.0 among Asian/ Pacific Islanders, and 2.7 among White women.[13] The rate of death from ovarian cancer was higher in women who were overweight - the risk went up by 50% in the heaviest women.[14] Studies have recognized that for women, being overweight or obese in adolescence or young adulthood is linked with an increased risk of being diagnosed with ovarian disease.[15]

Additionally, according to a study from the University of California at Berkeley, obese women "…are more likely than non-obese women to delay pap tests, pelvic exams and mammograms, even though they are "moderately" or "very concerned" about cancer."[16] They avoid or delay these procedures due to embarrassment, previous humiliating experiences, and lack of proper instruments, i.e. unsuitably sized equipment like speculums, exam tables, and fitting gowns.

Diabetes

Approximately 9.1 million women in the United States have diabetes. The prevalence of diabetes is at least two to four times higher among African American, Latino, Native American and Asian/Pacific Islander women than among Caucasian women.[17] Women with diabetes are at greater risk for heart disease and stroke. According to the Connecticut Department of Public Health, Black and Hispanic women have higher mortality rates due to diabetes and diabetes-related causes than White women. Between 1999 and 2001, Black women died at a rate of 40.2 per 100,000 and Hispanic women at a rate of 28.9, as compared to the rate of 14.1 for White women.[18] When analyzing diabetes-related deaths, the rates of death for Black and Hispanic women dramatically increased to a rate of 128.4 and 86.3 per 100,000 respectively, as compared to 53.5 for White women.[19]

Almost 1.25 million Connecticut adults are at increased risk of developing diabetes because they are overweight, have a sedentary lifestyle, or have a history of gestational diabetes, all of which are known risk factors.[20]

HIV/AIDS

Racial and ethnic populations have been disproportionately affected by the HIV/AIDS epidemic in Connecticut. Although Blacks/African-Americans and Hispanics represent 9.1% and 9.4% of Connecticut's population,[21] 62.3% of reported AIDS cases and 65.9% of reported HIV infections are among these populations.[22] Among women, the disparities are even more dramatic, with Black/African-American and Hispanic women representing 70.2% of females with AIDS, and 72.3% of females with HIV infection.[23]

The Causes

Two common risk factors for all of the above mentioned diseases, except HIV/AIDS, are obesity and smoking.

Obesity

Throughout the United States, obesity has increased in people of all ethnic groups, ages and genders. This is not an isolated threat to health, nor one limited to a particular population group. However, among some racial, ethnic and socioeconomic groups, the prevalence of obesity and many obesity-related risk factors are especially high.

Obesity is more common among African-American and Hispanic women and children. Among adult women, obesity is highest among African American and Mexican American women. Of females ages 20 and older, 77.3% of Black/African-American women, [24] and 71.7% of Mexican-American women are overweight or obese.[25] According to a national study conducted between 1986 and 1998, overweight prevalence rose more than 120% among African Americans and Hispanic children, compared to 50% among Whites.[26]

While personal choice plays a role in the rise of obesity, it alone is not responsible for the epidemic we face today. In some groups, lower incomes are associated with higher prevalence of obesity. Some low-income neighborhoods have many fast food restaurants, but few have stores or markets that sell nutritious foods. Women of lower socioeconomic status (incomes less than 130% of poverty threshold or $22,660 – $24,258 for a family of four) are about 50% more likely to be obese than those of higher socioeconomic status.[27]

Many lack access to safe places to play and be active. Communities with a higher percentage of African American residents tend to have fewer available parks and green spaces. Of African-American females age 18 and older, 55.2% are inactive, compared to 36.2% of White females.[28] Black and Hispanic children are significantly less likely than White children to report involvement in organized physical activity, as are children with parents who have lower income and educational levels.[29] In addition, many Americans of limited economic resources simply cannot purchase healthy food, join health clubs, or participate in organized sports or physical activity programs.

Smoking

Tobacco use has been a women's health issue dating back to the 1920's when tobacco companies recognized women as a target for their product. Since the 1980's there has been a dramatic increase in smoking related illnesses among women, including lung cancer and heart disease.[30]

In Connecticut, 18% of women smoke (283,100 women) and 7% are pregnant women.[31] The smoking rates in African-American and Hispanic communities continue to increase as tobacco companies continue to market to young African American and Hispanic women. Nationally, 19% of African American women,[32] and 11% of Hispanic women are current smokers.[33] Overall, in the United States, 20% of women smoke.[34]

For additional information, please contact:

The Connecticut Women's Health Campaign
Racial and Ethnic Disparities Committee
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Hartford, CT 06106
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www.cga.ct.gov/pcsw

[1] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, *Mortality by State, Race/Ethnicity, Gender, Age and Causes, 1999-2002*, accessed 9/05 at http://www.cdc.gov/nchs.
[2] American Heart Association. *Heart Disease and Stroke Statistics – 2004 Update*.
[3] *Ibid*.
[4] American Cancer Society. *Cancer, Facts and Figures 2005*. Atlanta, GA: American Cancer Society.
[5] *Ibid.*
[6] Campaign for Tobacco Fee Kids. *Tobacco Use and Hispanics,* 2006. http://www.tobaccofreekids.org/research/factsheets/pdf/0134.pdf.
[7]Centers for Disease Control and Prevention and National Cancer Institute. U.S. Cancer Statistics Working Group, 2005. *United States Cancer Statistics: 1999–2002 Incidence and Mortality Web-based Report*. Available at: www.cdc.gov/cancer/npcr/uscs.
[8] National Cancer Institute. *State Cancer Profiles 2002*, http://statecancerprofiles.cancer.gov/incidencerates/incidencerates.html
[9] Ries L.A.G., Eisner M.P., Kosary C.L., et al (eds). 2001. *SEER Cancer Statistics Review, 1973-1998* Bethesda, MD: National Cancer Institute.
[10] American Cancer Society. *Breast Cancer Facts and Figures 2001-2002.* Atlanta, GA: American Cancer Society.
[11] *General Ovarian Cancer Statistics: Ovarian Cancer is a Serious and Under-Recognized Threat to Women's Health*. http://www.ovariancancer.org/index.cfm?fuseaction=Page.viewPage&pageId=509&parentID=508&grandparentID=522&nodeID=1
[12] *Ibid*.
[13] Centers for Disease Control and Prevention, National Center for Health Statistics, *Healthy Women: State Trends in Health and Mortality*. http://www.4woman.gov/pub/steps/Cancer.htm
[14] *Overview: Ovarian Cancer. What Causes Ovarian Cancer?* http://www.cancer.org/docroot/CRI/content/CRI_2_2_2X_What_causes_ovarian_cancer_33.asp?rnav=cri
[15] National Cancer Institute. *Obesity and Cancer: Questions and Answers*. http://www.cancer.gov/newscenter/obesity1
[16] North American Association for the Study of Obesity (NAASO). http://www.naaso.org/news/20051017a.asp
[17] American Diabetes Association. www.diabetes.org/uedocuments/WomenFinal.pdf

[18] CT Department of Public Health. *Connecticut Resident Mortality Summary Tables by Gender, Race & Hispanic Ethnicity, 1999-2001*. Diabetes Deaths:
All females 83.2; Black females 40.2; Hispanic Females 28.9, White females: 14.1.
[19] *Ibid*. Diabetes-Related Deaths: All females 268.2; Black females 128.4; Hispanic Females 86.3, White females: 53.5.
[20] CT Department of Public Health. *Diabetes Fact Sheet* www.dph.state.ct.us/BCH/HEI/diabetes.htm
[21] U.S. Census Bureau, Census 2000, *Table DP-a. Profile of General Demographic Characteristics*.
[22] CT Department of Public Health. *CT HIV/AIDS Statistics through December 31, 2004*, available at www.dph.state.ct.us/BCH/infectiousdise/2003/final%20pages/topic_index_X.htm, accessed on 1/19/06. AIDS Cases: Total 13,889, White 5,178, Black 5,130, Hispanic 3,518, and Other 63. HIV Cases: Total 1,031; White 340, Black 281, Hispanic 398, and Other 12.
[23] *Ibid*. Females with AIDS: Total 3,840, White 1,130, Black 1,605, Hispanic 1,090, and Other 15. Females with HIV: Total 382; White 102, Black 122, Hispanic 154, and Other 4.
[24] *See*, endnote ii.
[25] Hedley AA et. al. P*revalence of overweight and obesity among US children, adolescents and adults, 1999-2002*. Jama 2004:291:2847-50 and Vital Health Stats, Feb 200, Series 10, No.219.
[26]*Ibid*.
[27] Dept HHS, *Healthy People 2010 2nd ed.*
[28] *See*, endnote ii.
[29] *Physical activity levels among children aged 9 – 13 years, United States, 2002*. MMWR 2003; 52 (33): 785-8.
[30] Campaign for Tobacco Free Kids. *Background on Women and Girls and Tobacco,2004*. http://www.tobaccofreekids.org/research/factsheets/pdf/0137.pdf
[31] Campaign for Tobacco Free Kids. *Mother's Day Data on Smoking Moms and Related Harms,2005.* http://www.tobaccofreekids.org/research/factsheets/pdf/0257.pdf
[32] Campaign for Tobacco Free Kids. *Tobacco Use Among African Americans, 2004*.
http://www.tobaccofreekids.org/research/factsheets/pdf/0006.pdf
[33] *See*, endnote v.
[34] *See*, endnote xxxi.

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How the Medicare Part D Prescription Drug Program will Affect Women in Connecticut

Federal changes in prescription drug plans

The federal Medicare Part D program, which began January 1, 2006, allows seniors and those with disabilities to join private prescription plans subsidized by the federal government. Plans must provide at least a "standard" package of drug benefits to all Medicare beneficiaries.[1] Under the federal law, Medicare beneficiaries with low incomes and assets will get subsidies with lower cost-sharing than higher income participants.[2]

The program covers only designated prescription drugs. Private plans are free to choose which Part D-covered drugs they will offer with certain exceptions. Our state Department of Social Services (DSS) has a new "wrap-around" to help those on Medicare Part D pay for drugs they had as ConnPACE or dually-eligible beneficiary,[3] including those not on the plan's list ("non-formulary" drugs).[4] Procedures for accessing drugs under the wrap-around are still being worked out. This fact sheet discusses why the Medicare Part D changes are of interest to Connecticut women, reviews our state's current policies and offers further contact information for consumers.

Medicare Part D disproportionately affects women

The majority of people who will be affected by the recent Medicare Part D changes are *women.* In fact, *elderly, disabled, low-income women and women of color are disproportionately affected by the Medicare Part D changes*.

The majority of Medicare, CONNPACE and the dual-eligible consumers are women.

- There are at least 257,252 women over age 65 in Connecticut. The majority of our elderly – or 58.7% are women.[5]
- Nationally, women make up 71% of the dually-eligible and over 55% of other Medicare participants.[6]

If we assume that the proportions of women participating in Medicare and Medicaid nationally are similar in Connecticut, that would mean that 55-70% of our CONNPACE participants would be women, (or 28,000-35,000 low-income elderly women); and approximately 70%, or 44,000 of the dual-eligibles in Connecticut would be women.[7]

More elderly women than men rely on life-saving medications, and older women tend to be more burdened by prescription drug costs than men.

- Low-income, widowed women are most likely to report problems paying for monthly prescriptions.[8]
- Older women are more likely to suffer from chronic illnesses that are improved by prescription drugs.
- Nationally, clinical depression affects two to three times as many women as men.[9]

- The Center for Medicare Advocacy estimates that twenty-three of the top 100 drugs used by CONNPACE (or Medicaid) participants in Connecticut are psychiatric drugs.
- Nearly three quarters of nursing home residents in the US are women, and almost half of these residents had dementia. Another 12% had other psychiatric conditions. [10]

Low-income women, women of color, and disabled women are at particular risk among our elderly, in part because women of color are more likely to suffer from serious health problems and have long-term health care needs than their white counter parts. Elderly women of color are also more likely to suffer dementia than their white counter parts. Women of color also tend to have lower incomes than elderly white women.[11]

Connecticut tries to fill gaps in federal drug program

The Connecticut General Assembly has acted to protect low- and moderate-income seniors, including older women from some of the "loopholes" in the federal plan with Public Act 05-02/HB 7702. This legislation was designed to:

- cover Medicare Part D non-formulary drugs for those in ConnPACE or the dually-eligible ($5 million "Medicare Part D Supplemental Needs Fund" at DSS)[12];
- protect CONNPACE participants from paying more than the $16.25 co-payment per prescription during the coverage gap;
- protect the dually-eligible from any prescription drug co-payments;
- fund $1 million of counseling to seniors to help them choose a pharmacy benefits plan; and
- allow DSS to establish a voluntary mail order option for all drugs under Part D plans.

These issues and others related to Medicare Part D in Connecticut will likely be discussed again in the 2006 legislative session.

What consumers should do at the pharmacy

Although Connecticut has attempted to fix some of the problems or "loopholes" in Medicare Part D, the program and Connecticut's policies are new, so there are many bumps to work out. Consumers who have CONNPACE or Medicaid and Medicare should bring their (grey) state CONNPACE card, (red, white and blue) Medicare card and their new Medicare drug plan card with them. Problems to watch out for:

- Consumer not found to be on a Medicare Part D plan;
- Medicaid client asked to pay co-pays for medications;
- ConnPACE clients asked to pay more than $16.25 for medications;
- Confusion about applicable prescription drug cards; or
- Erroneous denials by Part D plan

Pharmacies should give consumers prescriptions at no cost if clients are on Medicaid or for no more than $16.25 per medication if consumers are in ConnPACE.

For more information, call:

Statewide Legal Services 1-800-453-3320 CHOICES 1-800-994-9422

[1] The standard benefits (for people who are not on ConnPACE or dually eligible for Medicare and Medicaid) consist of (1) 75% coverage of prescription costs up to $ 2,250 with a $ 250 annual deductible; (2) no coverage beyond the $ 2,250 threshold until the beneficiary spends a total of $ 3,600 out-of-pocket ($ 5,100 in total consumer and Medicare expenditures), known as the "gap in standard coverage" or, informally, "the donut hole"; and (3) "catastrophic coverage" of 95% of all prescription costs above $5,100 (the beneficiary pays the greater of 5% of the cost per prescription or $ 2 for generic or preferred drugs and $ 5 for others). The plans may charge a monthly premium that can vary.

[2] Lower cost-sharing applies to co-pays, deductibles, "doughnut holes" and premium costs for "benchmark" plans.

[3] Dual-eligibles refer to people who participate in both Medicaid and Medicare at the same time.

[4] The federal law defines "Medicare Part D covered drug" as a prescription drug, biological product, insulin and related medical supplies, or vaccines, if they are used for a medical reason. Excluded drugs will be covered by Medicaid or ConnPACE to the extent they were previously covered.

[5] Current Population Survey, 2004.

[6] Kaiser Commission on Medicaid and the Uninsured. Dual Eligible: Medicaid's Role in Filling Medicare's Gaps. March 2004.

[7] Connecticut specific data on the numbers of women participating in CONNPACE or the dually-eligible program for Medicaid and Medicare were not available.

[8] American Association of Retired Persons. In Brief: Older Women's Access to Health Care: Potential Impact of Medicare Reform. July 2000.

[9] National Alliance on Mental Illness. "Women and Depression." 2005.

[10] American Association of Retired Persons. "Nursing Homes." February 2001.

[11] Henry J. Kaiser Family Foundation. Medicare and Minority Americans. 1999.

[12] DSS may require clients to first try to use the Part D plan's exception process. DSS must review all requests for assistance and notify beneficiariesof its decisions.